Early Periodic Screening Diagnosis and Treatment (EPSDT)
Audiology and Hearing Program

Early Periodic Screening Diagnosis and Treatment (EPSDT) Audiology and Hearing Program

I. PURPOSE:

This document will clarify the process to acquire hearing aids and audiology services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. EPSDT services are available to Medicaid/FAMIS Plus enrollees under 21 years of age and fee for service FAMIS enrollees under the age of 19. Hearing and Audiology services may be provided exclusively through EPSDT to eligible persons who have demonstrated a medical need for hearing devices and ongoing Audiology services.

II. BACKGROUND/DISCUSSION:

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the recipient.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or a DMAS-contracted managed care organization as medically necessary.

III. DEFINITIONS:

Analog Hearing Aids – These hearing devices use a traditional analog signal processor that allows minimal modifications by an audiologist. Analog hearing aids use older technology, are significantly lower in cost and require less time to modify than digital hearing aids.

Audiologist- A licensed professional who engages in the practice of audiology as defined by § 54.1-2600 of the Code of Virginia. "Audiology" means services provided by a qualified audiologist licensed by the Board of Audiology and Speech-Language Pathology and includes: the practice of conducting measurement, testing and evaluation relating to hearing and vestibular systems, including audiologic and electrophysiological measures, and conducting programs of identification, hearing conservation, habilitation, and rehabilitation for the purpose of identifying disorders of the hearing and vestibular systems and modifying communicative disorders related

to hearing loss including but not limited to vestibular evaluation, electrophysiological audiometry and cochlear implants. Any person offering services to the public under any descriptive name or title which would indicate that audiology services are being offered shall be deemed to be practicing audiology.

BICROS—"Bilateral Contra lateral Routing of Signal" type hearing aid.

BTE – "Behind The Ear" hearing aid

Centers for Medicare and Medicaid Services (CMS) – The federal agency that administers the Medicare, Medicaid and State Child Health Insurance programs.

CIC – "Completely In the Canal" type of hearing aid.

CROS – "Contra lateral Routing of Signal" type hearing aid.

Diagnostic and Treatment Services – Other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The state may determine the medical necessity of the service and subject the service to pre authorization for purposes of quality management review.

DMAS – **The Virginia Department of Medical Assistance Services**. DMAS is the state Medicaid agency and is responsible for administering the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) program.

EPSDT (**Early and Periodic Screening, Diagnostic, and Treatment) –** The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

EPSDT Screener – DMAS enrolled or contracted Medicaid Managed Care Organization (MCO) enrolled Physician, Physician's Assistant, or Nurse Practitioner.

EPSDT Screening – EPSDT screening services contain the following five (5) elements:

- A comprehensive health and developmental history, including assessment of both physical and mental health and development;

- A comprehensive unclothed physical examination;
- Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
- Laboratory tests, (including blood level assessment);
- Each encounter must be appropriate for age and risk factors, and Health education, including anticipatory guidance.

The chart below indicates when a child should receive an EPSDT screening:

INFANCY	**EARLY CHILDHOOD**	**LATE CHILDHOOD**	**ADOLESCENCE**
1 month	15 months	5 years	12 years
2 months	18 months	6 years	14 years
4 months	2 years	8 years	16 years
6 months	3 years	10 years	18 years
9 months	4 years		20 years
12 months			

ITC: In he Ear Canal type of hearing aid.

ITE: "In The Ear" type hearing aid.

FAMIS: FAMIS is Virginia's program that helps families provide health insurance to their children. FAMIS stands for Family Access to Medical Insurance Security Plan. FAMIS is a separate federal program from Medicaid. In Virginia, FAMIS recipients are not eligible for EPSDT treatment benefits when enrolled in a managed care organization. Children enrolled in FAMIS are eligible for hearing aid and audiological services that are equitable to Medicaid coverage.

Fee for Service and Managed Care: DMAS provides Medicaid to individuals through two programs: a program utilizing contracted managed care organizations (MCO) and fee-for-service (FFS), which is the standard Medicaid program. Enrollees in areas without a Managed Care Organization option or those who have insurance from a private carrier receive health benefits that are administered directly from DMAS. This benefit package is called "fee for service" and uses the DMAS provider network to receive healthcare services. "FAMIS fee for service" enrollees are eligible for EPSDT benefits when there is no Managed Care Organization that is contracted to serve their geographic region.

Hearing Aid Specialist: A person who engages in the practice of fitting and dealing in hearing aids or who advertises or displays a sign or represents himself as a person who practices the fitting and dealing of hearing aids. A Hearing Aid Specialist is licensed in Virginia by the Department of Professional and Occupational Regulation. Board for Hearing Aid Specialists for

the practice of fitting and dealing in hearing aids, as defined in § 54.1-1500 of the Code of Virginia.

Inter-periodic screenings: These are screenings that are provided outside of and in addition to the regular periodic screenings in the periodicity schedule above. For example, the PCP may choose to screen adolescents ages 11-20 in accordance with the AAP schedule rather than biannually as required by the current DMAS periodicity schedule. Any medical provider or a qualified health, developmental or educational professional who comes in contact with the child outside of the formal health care system may request that an inter-periodic screening be performed by the PCP or other screening provider.

MEDALLION: MEDALLION is Virginia's primary care case management (PCCM) managed care program administered by DMAS. Recipients in MEDALLION regions are required to select or be assigned to a primary care provider (PCP). The PCP receives a monthly management fee for their assigned recipients and is responsible for the coordination of all of the recipient's health care needs, including any necessary referrals.

Otolaryngologist: A licensed physician specializing in ear, nose and throat disorders.

Preauthorization (PA): The process of determining whether or not the service request meets all criterion for that service and gives authority to providers to allow reimbursement for services. Providers and individuals are notified of each PA decision with a system-generated notice. PA for MEDALLION and FFS enrollees is obtained at DMAS. PA for Managed Care enrollees must be obtained through the MCO.

State Plan for Medical Assistance or "the Plan": The federally approved plan outlining Virginia's Medicaid covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

Third Party Liability (TPL): When insurance other than Medicaid owned by the individual or purchased on the individual's behalf; may be liable for coverage of the requested Medicaid service. TPL must be billed for hearing and audiology services prior to billing Medicaid.

IV: PROVIDER REQUIREMENTS

Audiology

Audiology services can be provided by an Otolaryngologist or a licensed Audiologist.

An Otolaryngologist must have a current license as a physician with a specialty in Ear Nose and Throat medicine. An audiologist must have a current license from the Board of Audiology and Speech-Language Pathology.

Audiology services are not reimbursable by DMAS when provided by nursing staff or a hearing aid specialist without a license in audiology.

Hearing Aids:

All Hearing Aid dispensing providers must be licensed as a Hearing Aid Specialist by the Department of Professional and Occupational Regulations through the Board of Hearing Aid Specialists. Any professional who is a licensed audiologist or an otolaryngologist must have an additional license as a Hearing Aid Specialist in order to dispense hearing aids through DMAS.

Individuals who are licensed only as a Hearing Aid Specialist may enroll as a Hearing aid provider. Audiologists and other agency types may enroll separately as a hearing aid provider at their discretion in order to provide hearing aids.

If a licensed professional, a hearing aid specialist, or an agency that employs a hearing aid specialist wants to participate as an EPSDT Hearing Provider, they can find the DMAS provider application on the DMAS website at
http://www.dmas.virginia.gov/downloads/forms/pehearing_aid_provider.pdf
Providers may also apply by contacting Provider Enrollment at:

First Health - Provider Enrollment Unit
P.O. Box 26803
Richmond, Virginia 23261-6803

Helpdesk Telephone Numbers:
(804) 270-5105 local
(888)-829-5373 toll free

V. ELIGIBILITY CRITERIA:

EPSDT services are available to Medicaid/FAMIS Plus enrollees under 21 years of age and FAMIS fee for service enrollees under the age of 19.

Audiology and hearing aid services are provided to EPSDT eligible persons who have demonstrated a medical need for Audiology and Hearing Aid Services. An audiology evaluation is necessary to evaluate the need for treatment. DMAS will reimburse for audiological evaluations without pre authorization.

1. The individual must be enrolled in Medicaid/FAMIS Plus or FAMIS Fee for Service;
2. Audiology services are available based on referrals from outside agencies, schools and caregivers;
3. All hearing aids require a referral from the primary care physician or otolaryngologist;

4. Hearing Services must be provided through Hearing Aid Specialists, Audiologists, and Otolaryngologists who are currently licensed as a hearing aid specialist who have current participation agreements with DMAS.

VI. SERVICE INITIATION AND REFERRAL PROCESS:

Children under 18 years of age cannot be fitted with a hearing aid(s) unless the licensed Hearing Aid Specialist has been presented with a written statement signed by a licensed physician stating the child's hearing loss has been medically evaluated and the child may be considered a candidate for a hearing aid. The medical evaluation must have taken place within the preceding six months. The DMAS-352 form must be used to document the physician authorization and this form must be retained by providers related to all claims for new hearing aids.

All audiology and hearing aid services should be reported by the provider of services to the individual's primary physician and any other referring physicians or agencies to promote a medical home model of care and to allow the primary physician to be informed of these services as they may apply to all treatment services for the individual.

Hearing Services Referral Process

1. Evaluation by an Otolaryngologist, and/or audiologist to determine whether a hearing loss exists and the cause of the loss;
2. Medical intervention for correctable hearing losses by the physician;
3. Evaluation for hearing devices by an Otolaryngologist, and/or audiologist as appropriate to the type of hearing loss;
4. Referral to Hearing Aid Specialist for device acquisition per Virginia Hearing Aid Specialist regulations;
5. Device ordering/pre authorization as appropriate; and
6. Fitting and assessment of the hearing aid by an Audiologist and/or Hearing Aid Specialist;
7. Dispensation and fitting activities, instruction and follow up care of the hearing aid for the manufacturer's standard warranty period.

Audiology and Hearing Aid Services for Individuals in Managed Care Organizations

DMAS, its contracted MCOs and their providers have the responsibility to provide EPSDT diagnostic and treatment services to all Medicaid/FAMIS Plus enrollees under age 21. The full scope of EPSDT treatment is available to all children of Medicaid/FAMIS Plus regardless of their chosen MCO. Therefore, the EPSDT benefit is consistently available to all children enrolled in Medicaid/FAMIS Plus. The EPSDT screenings, treatment, and diagnostic benefits are the same whether they are provided through the enrollee's MCO provider network or through FFS provider network.

EPSDT audiology and hearing aid services are included in the services provided by a DMAS-contracted MCO. If an individual who is enrolled with a MCO requires audiology and hearing aid services the individual must contact the MCO medical management office to initiate audiology and hearing aid services.

MCO Addresses and Telephone Numbers can be found on the DMAS website at: http://www.dmas.virginia.gov/downloads/pdfs/mc-medicaid_MCO_Addr_Tel.pdf

VII. PREAUTHORIZATION REQUIREMENTS:

DMAS requires pre authorization for all hearing aids that do not have a reimbursement rate assigned (refer to the billing and exhibit section of this document) to their respective HCPCS code. If a device does not have a reimbursement rate or when the service frequency exceeds the allowed units for that device type then the device requires pre authorization. Devices that cost the provider beyond the assigned rate must be preauthorized.

> For example: the exceptions to this policy might be hearing devices which are required as part of a Bone Anchored Hearing (BAHA) system, hearing aids which are part of a cochlear implant, or FM Systems, or a repair cost that exceeds the allowance for V5014. Medical necessity will be reviewed for such instances to determine if the individual's hearing can be augmented appropriately with the use of lower cost items. In such cases preauthorization is required and the device function must be documented using objective measurements by a professionally calibrated instrument appropriate to measure the function of the device.

Requests for services may be faxed to: (804) 225-3961.

Requests for services may be mailed to:

> EPSDT Pre Authorization Coordinator
> Maternal and Child Health Division, 11th floor
> 600 E. Broad St., Suite 1300
> Richmond VA, 23219

Request for new hearing devices (new hearing aids) must contain the following:

1. Completed DMAS-352, signed by a physician including HCPCS codes for all related services;
2. Most recent audiological evaluation report
3. Quote from supplier to document provider's wholesale cost or cost description for requests to exceed allowed reimbursement rates
4. Discuss reasons for exceptional coverage requests

Requests for special cost consideration or repairs must contain

1. Quote from supplier to document provider's wholesale cost or cost description for requests to exceed allowed reimbursement rates
2. Discuss reasons for exceptional coverage requests

DMAS has 10 business days to process pre authorization requests for services. If the service request is approved, DMAS will provide a preauthorization number to the provider for use in claims. If the request is denied, notification will be sent to the provider and the enrollee and appeal rights will be provided to the enrollee.

MCO Service Requests

MCO enrollees must request hearing aids through their respective MCO.

VIII. COVERED SERVICES AND LIMITATIONS:

Audiology

Audiological evaluations are covered without pre authorization using the most current standard CPT codes. The list of covered services including service frequency limits are listed in the claims and billing section of this document.

DMAS will cover the full range of evaluative services for otolaryngology and audiology functioning. Audiology services must be provided by a licensed Audiologist or Otolaryngologist. When medically necessary, multiple assessments are allowed on the same day of service.

A qualified Audiologist may provide the following services:

- Identification of children with hearing loss;
- Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the rehabilitation of hearing;
- Referral for genetic counseling;
- Rehabilitation for the purpose of identifying disorders of the hearing and vestibular systems;
- Provision of treatment and therapeutic activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation, treatment related to cochlear implants;
- Creation and administration of programs for prevention of hearing loss;
- Guidance of children, parents, and teachers regarding hearing loss; and

- Determination of children's needs for group and individual amplification, selecting and fitting an appropriate aid, evaluating the effectiveness of amplification.

Hearing Aids and Related Devices

Hearing aids are a benefit available exclusively to individuals under the age of 21. All hearing aids without assigned rates as listed in this document and assistive devices such as FM systems require pre authorization. Hearing aid dispensation, fitting fees, device related repairs and supplies do not require pre authorization.

Hearing aid dispensing is allowed once each time a new hearing device is authorized and also when a hearing aid is replaced by the dispenser through a manufacturer's loss and damage policy.

A new hearing aid is allowed every 5 years. If an enrollee requires a new device within 5 years then pre authorization is required. Preauthorization decisions are based on medical necessity.

Ear molds (V5264) and supplies (V5267) such as cleaning kits for the hearing aid are allowed with each new hearing aid. Ear molds and supplies are billed using separate codes from the main hearing aid code and do not require pre authorization. Ear molds (V5264) can be made and billed as often as warranted due to child's growth and acoustic needs. The maximum allowance on supplies (V5267) can be billed only once per 2 year period.

Warranties, Repairs and Supplies

1. New hearing aids must carry the manufacturer's standard defect warranty and the loss and damage warranty.

2. DMAS will reimburse for repairs and an extended warranty fee using the hearing aid repair HCPCS code V5014. When a repair costs more than the DMAS allowed charge per unit, the additional amount requires pre authorization. A maximum of two repairs are allowed per year (per affected ear). Repair charges are not allowed when the manufacturer's original warranty is in effect.

3. Six batteries per ear per month are allowed. For example = 36 units for six months for one ear or 72 units for six months for two ears. Each month's allowance must be listed separately on the claim form. Providers should bill the maximum allowance of six units within the calendar month.

IX. DOCUMENTATION REQUIREMENTS

Audiology Documentation

Documentation for audiology assessment, evaluation and treatment services must be kept in the enrollees' record and must include the following:

1. Any assessments and/or evaluation reports including documentation of correspondence with the medical home for the enrollee;
2. The testing methods used in the hearing aid evaluation including real ear measurements;
3. A plan of care specifically designed for the enrollee who is receiving treatment services. Treatment notes include the anticipated level of functional improvement and documentation of functional improvements, any therapeutic interventions to be addressed by the audiologist, and identification of a discharge and/or maintenance plan; and
4. Recommendations for follow-up care should be noted in reports to physicians or others involved in the enrollees care.

Hearing Aid Documentation

All hearing aids require a referral from the primary care physician or otolaryngologist in order to meet federal EPSDT requirements. This can be completed using the DMAS-352 Certificate of Medical Necessity (CMN). This form may be obtained from the forms section of the DMAS website (www.dmas.virginia.gov).

352 Documentation Requirements:

- Demographic data including provider identification information is entered in section I;
- Enrollee information including diagnosis codes are entered in section II;
- Device/Equipment are indicated in section III;
- Request information must include the specific HCPCS code and the quantity for the prescribed hearing aid in section III; and
- The ordering physicians name, signature, and Medicaid provider number are provided in section IV.

Ongoing Service Documentation:

- The date and necessity for services such as repairs, maintenance of devices and compliance with warranty requirements by the enrollee and the supplying manufacturer;
- Reasons for fitting fee and dispensation related services;
- Reasons for new ear molds;
- Documentation of all supply ordering and delivery of each hearing device and supply provided;
- Documentation of all hearing aid checks and associated real ear measurements; and
- Documentation of all follow-up care for persons with cochlear implants.

X. BILLING:

Billing For Covered Hearing Aid Services

Billing codes for covered hearing aids and hearing aid supplies are indicated in the billing chapter of this document.

TPL benefits must be used prior to billing DMAS for hearing aids and audiology services.

Two major areas are covered in this section:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

ELECTRONIC SUBMISSION OF CLAIMS
Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800)-924-6741
Fax number: (804)-273-6797
First Health's Website: http://virginia.fhsc.com or by mail

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

TIMELY FILING
The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See the Provider Services section of the DMAS website) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local Department of Social Services indicating the delayed claim information must be attached to the claim.

- **Denied Claims** Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the CMS-1500 (08-05) invoice as explained under the "Instructions for the Use of the CMS-1500 (08-05) Billing Form" elsewhere in this chapter.

  - **Attach** written documentation to verify the explanation. The word "attachment" must be included in 10D. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See the Provider Services section of the DMAS website).

  - Indicate Unusual Service by entering "22" in Locator 24D of the - CMS-1500 (08-05) claim form.

  - Submit the claim in the usual manner by mailing the claim to:

    Department of Medical Assistance Services
    Practitioner
    P. O. Box 27444
    Richmond, Virginia 23261-7444

  The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid can make no reimbursement if the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid can make no reimbursements if the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

- **Other Insurance**- The recipient can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid recipient. For recipients with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while you have Medicaid without penalty from your insurance company. The recipients must notify the insurance company. The recipient must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

BILLING INVOICES

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below are the three billing invoices to be used:

- Health Insurance Claim Form, CMS-1500 (08/05)
- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30) Rev 05/06
- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Invoice (DMAS-31) Rev 05/06

The requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid recipients who are dually eligible for Medicare and Medicaid.

However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible recipients are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid ID as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a Virginia Medicaid ID, the claim will be processed by DMAS using the Virginia Medicaid number rather than the Medicare vendor number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier "1D" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid ID on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims.

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (08-05)

The CMS-1500 (08-05) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402
(202)`512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (08-05) will not be provided by DMAS.

The request for forms or Billing Supplies must be submitted by:

1. Mail Your Request To:
   Commonwealth Mailing
   1700 Venable St.
   Richmond, VA 23223

2. Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, by Faxing the DMAS order desk at Commonwealth Martin 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

REMITTANCE/PAYMENT VOUCHER
DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in

general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 Health Care Claim Payment advice
The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835.

In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800)-924-6741.

CLAIM INQUIRIES and Reconsideration
Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based

Automated Response System. See Chapter I for more information.

BILLING PROCEDURES
Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC FILING REQUIREMENTS
The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will be accepted.

Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions.

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for pre authorization request and response
- Unsolicited 277 for reporting information on pended claims

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: http://virginia.fhsc.com.

CLAIMCHECK

Re-implementation of ClaimCheck editing software was done January 9, 2006 for all physician and laboratory services received on this date. ClaimCheck is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimCheck edits are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or post-operative time frame. DMAS will recognize the following modifiers, when appropriately used as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck process. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. The Division of Program Integrity will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

The modifiers that currently bypass the ClaimCheck edits are:

- Modifier 24 – Unrelated E & M service by the same physician during the post-operative period
- Modifier 25 – Significant, separately identifiable E & M service on the same day by the same physician on the same day of the procedure or other services.
- Modifier 57 – Decision for Surgery
- Modifier 59 – Distinct Procedural Service
- Modifiers U1-U9 – State-Specific Modifiers

Providers that disagree with the action taken by a ClaimCheck edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Department of Medical Assistance Services
Payment Processing Unit – ClaimCheck
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Reconsideration /Appeals

Requests for reconsideration of denied services, resulting from claimcheck should be sent with additional supporting documentation to:

Payment Processing Unit, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

Provider Appeals

If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§9-6.14:1 through -6.14:25) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia et seq and § 32.1-325.1.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING PRE AUTHORIZATION

PLEASE REFER TO THE "HEARING AND AUDIOLOGY CODES" AS LISTED BELOW.

All hearing aids without assigned rates as listed in this document and assistive devices such as FM systems require pre authorization. Hearing aid dispensation, fitting fees, device related repairs and supplies do not require pre authorization.

NSTRUCTIONS FOR USE OF THE CMS-1500 (08-05), BILLING FORM
These instructions are to be used for this new form during the dual billing period beginning March 26, 2007. Providers are encouraged to monitor all Medicaid memorandums and the DMAS web site(s) for additional directions.

To bill for services, the Health Insurance Claim Form, CMS-1500 (08-05), invoice form must be used for claims received on or after March 26, 2007**.** The following instructions have numbered items corresponding to fields on the CMS-1500 (08-05). The purpose of the CMS-1500 (08-05) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid enrollees.

SPECIAL NOTE: Providers who will be using this form beginning March 26, 2007 can use their current Medicaid Provider Number with the '1D' qualifier in locations 17a, 24I & J, lines 1-6. Also, the provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use. After NPI Compliance, all locators dealing with provider identification numbers must contain only NPI or API's.

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).**
1a	**REQUIRED**	**Insured's I.D. Number -** Enter the 12-digit Virginia Medicaid Identification number for the enrollee receiving the service.
2	**REQUIRED**	**Patient's Name -** Enter the name of the enrollee receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name

Locator		Instructions
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: -** Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) **NOTE:** The state postal code should be entered if known.
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form and whenever the procedure modifier "22" (unusual services) is used.** If modifier '22' is used, documentation should be attached to provide information that is needed to be considered.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	**REQUIRED If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid Managed Care Organizations copays- please insert **"HMO Copay".**
11d	**REQUIRED If applicable**	**Is There Another Health Benefit Plan?** Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED If applicable**	**Name of Referring Physician or Other Source** - Enter the name of the referring physician.
17a	**REQUIRED**	**I.D. Number of Referring Physician** - Enter the '1D'

Locator		Instructions
shaded red	**If applicable**	qualifier in first block followed by the current Medicaid provider number if the claim is received prior to or on March 26, 2007. If the claims is received on or after March 26, 2007, the '1D' qualifier should be used when the current Medicaid provider number or the Atypical Provider Identifier (API) is entered. Beginning with claims received on or after March 26, 2007 if the NPI is entered in 17b, then in locator 17a, the qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. See Special Billing Instructions at the end of these instructions for specific services.
17b	**REQUIRED If applicable**	**I.D. Number of Referring Physician -** Enter the NPI of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**REQUIRED If applicable**	**CLIA # -** Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 1-4	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD-9-CM diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line #1 field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in line # 2-4.
22	**REQUIRED If applicable**	**Medicaid Resubmission - Original Reference Number.** Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	**REQUIRED If applicable**	**Prior Authorization (PA) Number** - Enter the PA number for approved services that require a prior authorization.

NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. **The shaded area is ONLY for supplemental information**. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing.

24A lines 1-6 open	**REQUIRED**	**Dates of Service -** Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 10/01/06). DATES MUST BE WITHIN THE SAME MONTH

Locator area		Instructions
24A lines 1-6 red shaded	**REQUIRED If applicable**	**DMAS is requiring the use of qualifier 'TPL'.** This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled as TPL27.08. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required. **DMAS is requiring the use of the qualifier 'N4'.** This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS J-code is submitted in 24D to DMAS. Example: N400026064871. No spaces between the qualifier and the NDC number. **Note: Information is to be left justified.**
		SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed: • If there is nothing indicated or the NO is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2. • If locator 11d is checked YES and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. • If locator 11d is checked YES and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of $15.50. This relates to the old coordination of benefit code 3.
24B open area	**REQUIRED**	**Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	**REQUIRED If applicable**	**Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier -** Enter the appropriate CPT/HCPCS modifiers if applicable. **NOTE:** Use modifier "22" for individual consideration only when there is an attachment that provides additional information related to the processing of the claim. All claims with this modifier will pend for manual review.

Locator		Instructions
24E open area	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference number (pointer) as shown in Locator 21 to relate the date of service and the procedure preformed to the primary diagnosis. NOTE: Only the first reference number (1, or 2, or 3, or 4) digit code is captured by DMAS. Claims with values other than 1, 2, 3, or 4 in Locator 24-E may be denied.
24F open area	**REQUIRED**	**Charges -** Enter your total usual and customary charges for the procedure/services.
24G open area	**REQUIRED**	**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED**	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	**REQUIRED If applicable**	**NPI** - This is to identify that it is a NPI that is in locator 24J
24 I red-shaded	**REQUIRED If applicable**	**ID QUALIFIER** - Enter qualifier '1D' for the current Medicaid provider number that is required for claims received beginning March 26, 2007. For claims received on or after March 26, 2007, the qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. After NPI Compliance, the qualifier '1D' will still be required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care. **NOTE:** This locator cannot be used for claims received before March 26, 2007.
24J red-shaded	**REQUIRED If applicable**	**Rendering provider ID#** - Enter qualifier '1D' for the current Medicaid provider number of the rendering provider that is required for claims received beginning March 26, 2007. After NPI Compliance, the qualifier '1D' will still be required for the API entered in this locator. For claims received on or after March 26, 2007 the qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.

Locator		Instructions
25	NOT REQUIRED	Federal Tax I.D. Number
26	**REQUIRED**	**Patient's Account Number** – Up to **FOURTEEN** alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6
29	**NOT REQUIRED**	**Amount Paid**.
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32	**REQUIRED If applicable**	**Service Facility Location Information** - Enter the name as first line, address as second line, city, state and **9-digit** zip code as 3rd line for the location where the services were rendered. **NOTE:** For DME providers with multiple office locations, the specific Zip code must reflect the location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the **9-digit** zip code.
32a open	**REQUIRED If applicable**	**NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	**REQUIRED If applicable**	**Other ID#:** - Enter the qualifier '1D' for the current Medicaid provider number or the assigned API for claims received beginning March 26, 2007. After NPI Compliance, the qualifier '1D' will still be required for the API entered in this locator. For claims received on or after March 26, 2007 the qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and **9-digit** zip code as third line. This locator is to identify the provider that is requesting to be paid**.** **NOTE:** Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include

Locator		Instructions
		the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	**REQUIRED**	**NPI –** Enter the 10-digit NPI number of the billing provider. **NOTE:** DMAS will allow group billing providers starting with our dual use NPI implementation beginning March 26, 2007. Providers who have established group billing & received confirmation from DMAS may submit the group NPI in this location.
33b red shaded	**REQUIRED If applicable**	**Other Billing ID -** Enter qualifier '1D' for the current Medicaid provider number or the API of the rendering provider that is required for claims received beginning March 26, 2007. After NPI Compliance, the qualifier '1D' will still be required for the API entered in this locator. For claims received on or after March 26, 2007, the qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 33a open line. **NOTE:** Do NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (08-05), as an Adjustment Invoice

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (08-05), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the **4**-digit code identifying the reason for the submission of the adjustment invoice.

1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment

1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/service code
1029	Correcting diagnosis code
1030	Correcting charges
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (08-05) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (08-05), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (08-05), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the ~~4~~ digit code identifying the reason for the submission of the void invoice.

1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (08-05) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

Group Practice Billing Functionality
Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility-based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS-1500 (08-05), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, “less the negative balance” and it may also show “the negative balance to be carried forward”.

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form. The invoice is completed and submitted according to the instructions provided in the Medicaid *Physician Manual* issued by DMAS.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number or the NPI of the PCP in Locator 17a of the CMS-1500, as noted within the billing instructions. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

SPECIAL BILLING INSTRUCTIONS -- CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care provider (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider's NPI in locator 17b or the API in Locator 17a with the qualifier '1D'and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "Y" in Locator 24C and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.
17	Enter the name of the referring primary care provider.
17a red shaded	When a restricted enrollee is treated on referral from the primary physician, enter the qualifier '1D' and the appropriate provider number (current Medicaid or an API) (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d. **Note:** Please refer to the time line for the appropriate provider number as indicated in main instruction above.
17b open	When a restricted enrollee is treated on referral from the primary physician, enter the NPI number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d. **Note:** This locator can only be used for claims received on or after March 26, 2007.
24C	When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "Y" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10D.

EDI BILLING (ELECTRONIC CLAIMS)

Please refer to X-12 Standard Transactions & our Comparison Guides that are listed in the chapter.

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

The Virginia Medical Assistance Program implemented the consolidation process for Virginia Medicare crossover process, referred to as the Coordination of Benefits Agreement (COBA) in January 23, 2006. This process resulted in the transferring the claims crossover functions from individual Medicare contractors to one national claims crossover contractor.

When crossover claims are processed by the Virginia Medicaid Program, DMAS must be able to match a Virginia Medicare vendor number to a valid Virginia Medicaid provider number to pay the claim.

The COBA process is only using the 837 electronic claims format. To insure that Virginia Medicaid correctly reimburses the provider, it is recommended that the provider include their Medicaid provider number as the secondary payer on claims submitted to Medicare with the qualifier "1D". If the Medicaid provider number is submitted, then DMAS will process the claim using this provider number and will not have to determine the Medicaid number utilizing the Medicare vendor number. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (https://virginia.fhsc.com/hipaa/CcompanionGuides.asp) for more information.

Beginning March 1, 2006, Virginia Medicaid began accepting secondary claims to Medicaid when Medicare is primary from providers and not just thru the COBA process. If you receive notification that your Medicare claims did not cross to Virginia Medicaid or the crossover claim has not shown on your Medicaid remittance advice after 30 days, you should submit your claim directly to Medicaid. These claim can be resubmitted directly to DMAS either electronically or by using the DMAS-30 R 5/06 (original) or DMAS-31 R 5/06 (adjustment/void) paper claim form. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (https://virginia.fhsc.com/hipaa/CompanionGuides.asp) for more information.

An electronic claim can be sent to Virginia Medicaid if you need to resubmit a crossover claim that originally denied, such as for other coverage, or if you need to adjust or void a paid crossover claim, such as to include patient liability.

NOTE: Medicaid eligibility is reaffirmed each month for most enrollees. Therefore, bills must be for services provided during each calendar month, e.g., 01/01/06 – 01/31/06.

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice FOR PART B ONLY, DMAS-30 – R 5/06

Purpose: **A method of billing Medicare's deductible and coinsurance for professional services received by a Medicaid enrollee in the Virginia Medicaid program.**

NOTE: This form can be used for four different procedures **per** Medicaid enrollee and rendering provider. A different form must be used for **each** Medicaid enrollee and rendering provider.

Block 01 **Billing Provider Number** – Enter the billing provider identification number used by Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears on the enrollee's eligibility card.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears on the enrollee's eligibility card.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Rendering Provider Number** – Enter the rendering provider number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 – No Other Coverage** – If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – **Mark type of coverage B only.**

Block 09 **Diagnosis** – Enter the principal diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission (if applicable).

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **NDC –** Enter NDC, if applicable

Block 25 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files.

Mail the completed claims to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

Instructions for the completion of the department of medical assistance services (title xviii) Medicare Deductible and coinsurance adjustment/void invoice for PART B ONLY DMAS 31 R 5/06

Adjustment/Void Invoice, DMAS-31 (Revised 5/06)

An adjustment is submitted to the change information on a paid claim.

A void is submitted to void an original payment. The information on the invoice must be identical to the original invoice.

Purpose	To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied or pended claims.
Explanation	To void the original payment, the information on the adjustment/void invoice must be identical to the original invoice. To correct the original payment, the adjustment/void invoice must appear exactly as the original should have.
Block 1	**Adjustment/Void** - Check the appropriate block.
Block 2	**Billing Provider Number** – Enter the billing provider identification number used by Virginia Medicaid.
Block 2A	**ICN/Reference Number** - Enter the ICN/reference number, indicated on the remittance voucher of the claim to be adjusted or voided. The adjustment or void can not be processed without this number.
Block 2B	**Reason** - Leave blank.
Block 2C	**Input Code** - Leave blank.
Block 3-24	Please refer to DMAS -30 (rev 5/06) for the completion of these blocks.
Remarks	This section of the invoice should be used to give a brief explanation of the change needed.

Signature Signature of the provider or the agent and the date signed are required.

III. Mechanics and Disposition The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files.

Mail the completed claims to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
    - **Approved** - Payment is approved or Pended Claims are placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
    - **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

Exhibit

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DMAS Hearing Aid and Audiology Reimbursement Rates
Effective 1.1.2008

Proc Codes	DMAS Hearing Program Current Procedural Codes Service Description	Fees	Service Limit
HCPCS	***Devices use HCPCS system, assessment uses CPT*		
V5008	HEARING SCREENING	**0**	Use CPT
V5010	ASSESSMENT FOR HEARING AID	**0**	Use CPT
V5010	ASSESSMENT FOR HEARING AID	**0**	Use CPT
V5011	FITTING, ORIENTATION/ CHECKING OF HEARING AID	**80**	4 per year
V5014	REPAIR/MODIFICATION OF HEARING AID	**150**	2 per year
V5020	CONFORMITY EVALUATION	**0**	
V5030	HEARING AID, MONAURAL, BODY WORN, AIR CONDUCTION	**550**	1 per 60 mos
V5040	HEARING AID, MONAURAL, BODY WORN, BONE CONDUCTION	**550**	1 per 60 mos
V5050	HEARING AID, MONAURAL, IN THE EAR (ITE)	**550**	1 per 60 mos
V5060	HEARING AID, MONAURAL, BEHIND THE EAR (BTE)	**550**	1 per 60 mos
V5070	GLASSES, AIR CONDUCTION	**IC**	1 per 60 mos
V5080	GLASSES, BONE CONDUCTION	**IC**	1 per 60 mos
V5090	DISPENSING FEE, UNSPECIFIED HEARING AID	**300**	1 per 60 mos
V5095	SEMI-IMPLANTABLE MIDDLE EAR HEARING	**IC**	1 per 60 mos
V5100	HEARING AID, BILATERAL, BODY WORN	**IC**	1 per 60 mos
V5110	DISPENSING FEE, BILATERAL	**600**	1 per 60 mos
V5120	BINAURAL, BODY	**IC**	1 per 60 mos
V5130	HEARING AID, BINAURAL, ITE	**1100**	1 per 60 mos
V5140	HEARING AID, BINAURAL, BTE	**1100**	1 per 60 mos
V5150	BINAURAL, GLASSES	**IC**	1 per 60 mos
V5160	DISPENSING FEE, BINAURAL	**600**	1 per 60 mos
V5170	HEARING AID, CROS, IN THE EAR	**IC**	1 per 60 mos
V5180	HEARING AID, CROS, BEHIND THE EAR	**IC**	1 per 60 mos
V5200	DISPENSING FEE, CROS	**300**	1 per 60 mos
V5210	HEARING AID, BICROS, IN THE EAR	**IC**	1 per 60 mos
V5220	HEARING AID, BICROS, BEHIND THE EAR	**IC**	1 per 60 mos
V5241	DISPENSING FEE, MONAURAL HEARING AID, ANY TYPE	**300**	1 per 60 mos
V5242	HEARING AID, ANALOG, MONAURAL, CIC (COMPLETELY IN THE EAR CANAL)	**IC**	1 per 60 mos
V5243	HEARING AID, ANALOG, MONAURAL, ITC (IN THE CANAL)	**550**	1 per 60 mos
V5244	Hearing Aid / Digitally Programmable Analog / Monaural / CIC	**IC**	1 per 60 mos
V5245	Hearing Aid / Digitally Programmable Analog / Monaural / ITC (Canal)	**IC**	1 per 60 mos
V5246	Hearing Aid / Digitally Programmable Analog / Monaural / ITE (In-the-Ear)	**IC**	1 per 60 mos
V5247	Hearing Aid / Digitally Programmable Analog / Monaural / BTE	**IC**	1 per 60 mos

	(Behind-the-Ear)		
V5248	HEARING AID, ANALOG, BINAURAL, CIC	**IC**	1 per 60 mos
V5249	HEARING AID, ANALOG, BINAURAL, ITC	**1200**	1 per 60 mos
V5250	Hearing Aid / Digitally Programmable / Analog /Binaural /CIC (Completely in Canal)	**IC**	1 per 60 mos
V5251	Hearing Aid / Digitally Programmable / Analog /Binaural /ITC (Canal)	**IC**	1 per 60 mos
V5252	Hearing Aid / Digitally Programmable / Analog /Binaural /ITE (In-the-Ear)	**IC**	1 per 60 mos
V5253	Hearing Aid / Digitally Programmable / Analog /Binaural /BTE(Behind-the_Ear)	**IC**	1 per 60 mos
V5254	HEARING AID, DIGITAL, MONAURAL, CIC	**IC**	1 per 60 mos
V5255	HEARING AID, DIGITAL, MONAURAL, ITC	**1175**	1 per 60 mos
V5256	HEARING AID, DIGITAL, MONAURAL, ITE	**1175**	1 per 60 mos
V5257	HEARING AID, DIGITAL MONAURAL BTE	**1175**	1 per 60 mos
V5258	HEARING AID, DIGITAL, BINAURAL, CIC	**2350**	1 per 60 mos
V5259	HEARING AID, DIGITAL, BINAURAL, ITC	**2350**	1 per 60 mos
V5260	HEARING AID, DIGITAL, BINAURAL, ITE	**2350**	1 per 60 mos
V5261	HEARING AID, DIGITAL, BINAURAL, BTE	**2350**	1 per 60 mos
V5262	Hearing Aid / Disposable / Any Type / Monaural	**0**	1 per 60 mos
V5263	Hearing Aid / Disposable / Any Type / Binaural	**0**	1 per 60 mos
V5264	EAR MOLD/ INSERT, NOT DISPOSABLE, ANY TYPE	**35**	2 per 3 mos
V5266	BATTERY FOR USE IN HEARING DEVICE	**1**	6 per month
V5267	HEARINGAID SUPPLIES	**47.75**	2 per year
V5273	ASSISTIVE LEARNING DEVICE COCHLEAR IMPLANT TYPE	**IC**	1 per 60 mos
V5274	ASSISTIVE LEARNING DEVICE (FM system)	**IC**	1 per 60 mos
V5275	EAR IMPRESSION, EACH	**IC**	not covered
V5298	HEARING AID, NOT OTHERWISE CLASSIFI	**IC**	1 per 60 mos
V5299	HEARING SERVICE, MISCELLANEOUS	**IC**	1 per 60 mos

Hearing Assessment and Evaluation Codes

CPT Codes

PROC CODE	PROCEDURE DESCRIPTION	MAX RATE	Service Limits
92551	SCREENING TEST, PURE TONE, AIR ONLY	7.07	N/A
92552	PURE TONE AUDIOMETRY (THRESHOLD); A	13.87	N/A
92553	PURE TONE AUDIOMETRY (THRESHOLD); A	19.86	N/A
92555	SPEECH AUDIOMETRY THRESHOLD;	11.42	N/A
92556	SPEECH AUDIOMETRY THRESHOLD; WITH S	16.86	N/A
92557	COMPREHENSIVE AUDIOMETRY THRESHOLD	36.17	N/A
92559	AUDIOMETRIC TESTING OF GROUPS	15.75	N/A
92560	BEKESY AUDIOMETRY; SCREENING	23.68	N/A
92561	BEKESY AUDIOMETRY; DIAGNOSTIC	20.94	N/A

92562	LOUDNESS BALANCE TEST, ALTERNATE BI		14.14	N/A
92563	TONE DECAY TEST		12.23	N/A
92564	SHORT INCREMENT SENSITIVITY INDEX (		13.87	N/A
92565	STENGER TEST, PURE TONE		10.88	N/A
92567	TYMPANOMETRY (IMPEDANCE TESTING)		15.5	N/A
92568	ACOUSTIC REFL THRESHOLD TST		9.79	N/A
92569	ACOUSTIC REFLEX DECAY TEST		10.61	N/A
92571	FILTERED SPEECH TEST		11.7	N/A
92572	STAGGERED SPONDAIC WORD TEST		6.26	N/A
92573	LOMBARD TEST		9.94	N/A
92575	SENSORINEURAL ACUITY LEVEL TEST		14.14	N/A
92576	SYNTHETIC SENTENCE IDENTIFICATION T		14.14	N/A
92577	STENGER TEST, SPEECH		18.22	N/A
92579	VISUAL REINFORCEMENT AUDIOMETRY (VR		22.3	N/A
92582	CONDITIONING PLAY AUDIOMETRY		23.93	N/A
92583	SELECT PICTURE AUDIOMETRY		25.02	N/A
92584	ELECTROCOCHLEOGRAPHY		63.9	N/A
92585	AUDITORY EVOKED POTENTIALS FOR EVOK		73.15	N/A
92586	AUDITORY EVOKED POTENTIALS FOR EVOK		51.12	N/A
92587	EVOKED OTOACOUSTIC EMISSIONS; LIMIT		39.15	N/A
92588	EVOKED OTOACOUSTIC EMISSIONS; COMPR		53.84	N/A
92589	CENTRAL AUDITORY FUNCTION TEST(S) (		15.2	N/A
92590	HEARING AID EXAMINATION AND SELECTION MONAURAL		41.61	N/A
92591	HEARING AID EXAMINATION AND SELECTION BINAURAL		77.29	N/A
92592	HEARING AID CHECK; MONAURAL		80	6 per year
92593	HEARING AID CHECK; BINAURAL		80	6 per year
92594	ELECTROACOUSTIC EVALUATION FOR HEAR	IC		N/A
92595	ELECTROACOUSTIC EVALUATION FOR HEAR	IC		N/A
92596	EAR PROTECTOR ATTENUATION MEASUREME	IC		N/A
92597	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHESIS		66.99	N/A
92601	DIAGNOSTIC ANALYSIS OF COCHLEAR IMP		106.33	N/A
92602	DIAGNOSTIC ANALYSIS OF COCHLEAR IMP		73.15	N/A
92603	DIAGNOSTIC ANALYSIS OF COCHLEAR IMP		67.17	N/A
92604	DIAGNOSTIC ANALYSIS OF COCHLEAR IMP		43.79	N/A
92620	AUDITORY FUNCTION, 60 MIN		37.53	N/A
92621	AUDITORY FUNCTION, + 15 MIN		9.51	N/A
92625	TINNITUS ASSESSMENT		36.98	N/A
92626	EVAL AUD REHAB STATUS		59.01	N/A
92627	EVAL AUD STATUS REHAB ADD-ON		14.69	N/A
92630	AUD REHAB PRE-LING HEAR LOSS		95.91	N/A
92633	AUD REHAB POSTLING HEAR LOSS		95.91	N/A
92700	UNLISTED OTORHINOLARYNGOLOGICAL SER	IC		N/A